ID #: _____

Minnesota WIC Program

Authorization of Milk Substitutes

Federal Rules governing the WIC program require medical authorization from a Health Care Provider for any participant for whom a higher calorie milk option or milk substitute has been determined beneficial. The food being requested is marked below.

- Please indicate the reason the food is medically required. If there are any contraindications to the milk substitute prescribed below, indicate why in Special Instructions below.
- By signing this form you are acknowledging that this WIC participant is under your care and you have authorized the WIC health professional to prescribe the following substitution based upon a nutritional assessment completed by WIC.
- This approval is valid for 1 year from date of signature unless otherwise noted.

Participant's Name: _____ (last name, first name) **Date of Birth:** _____

Parent / Caregiver: _____ (last name, first name) **Phone:** _____

☐ **Requested Higher Calorie Milk / Cheese Option:**

- ☐ **Cheese**: if requesting > 1 lb. for woman/child or > 2 lb. for fully breastfeeding woman
- ☐ **Whole Milk or 2% Milk:** if requesting for woman or child ≥ 2 years

Indicate the reason the higher calorie milk/cheese option is required:

- ☐ Underweight: Child: ≤ 5th% weight/length or BMI. Woman: Underweight per BMI.
- ☐ Weight loss: due to ongoing medical condition that has persisted ≥ 6 months
- ☐ Pregnancy: current inadequate weight gain
- ☐ Do not provide

Special Instructions:

☐ **Requested Milk Substitute:** ***Note: Lactose-free milk is available with no authorization necessary.***

- ☐ **Soy Beverage:** if requesting for a child
- ☐ **Tofu:** if requesting any amount for a child, > 4 lb. for a woman, or > 6 lb. for a fully breastfeeding woman

Indicate the reason the milk substitute is required:

- ☐ Milk allergy
- ☐ Vegan / vegetarian diet
- ☐ Religious or cultural observance/practice
- ☐ Do not provide milk substitute

Special Instructions:

Signature (Health Care Provider): _____ **Date:** _____

Printed Name (Health Care Provider): _____ ☐ **MD** ☐ **DO** ☐ **NP** ☐ **CNM** ☐ **PA**

Medical Office / Clinic: _____ **Phone:** _____

Address: **Fax:**

Return completed form to:

Fax Number: 952-891-7565 Attn: - Phone: -

OR Mail to: Dakota County Public Health – WIC 14955 Galaxie Avenue Apple Valley, MN 55124

This institution is an equal opportunity provider.

DCPHD-WIC-1528 (8/09)